FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038745

Facility Name: FAIRVIEW NURSING HOME

Address: 701 NORTH LAGRANGE R (Number) LAGRANGE PARK (City) 60525 (Zip Code)

County: COOK

Telephone Number: (847) 354-7300 **Fax #** (847) 354-8928

IDPA ID Number: 363874603001

Date of Initial License for Current Owners: 04/16/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,000	1,364	3,309	5,673	8
9	SNF/PED					9
10	ICF	26,194	8,604	1,319	36,117	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,194	9,968	4,628	41,790	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.40%

D. How many bed-hold days during this year were paid by Public Aid?
22 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/16/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/16/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2514

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	184,645	22,979	15,526	223,150		223,150	(8,098)	215,052			1
2	Food Purchase		156,018		156,018	(21,280)	134,739	6,274	141,013			2
3	Housekeeping	251,004	30,044		281,048		281,048	1,300	282,348			3
4	Laundry	89,958	21,308		111,266		111,266		111,266			4
5	Heat and Other Utilities			145,906	145,906		145,906	1,722	147,628			5
6	Maintenance	37,514		88,459	125,973		125,973	1,011	126,984			6
7	Other (specify):*							1,703	1,703			7
8	**TOTAL General Services**	563,121	230,349	249,891	1,043,361	(21,280)	1,022,082	3,911	1,025,993			8
	B. Health Care and Programs											
9	Medical Director			16,785	16,785		16,785		16,785			9
10	Nursing and Medical Records	1,748,473	74,189	82,933	1,905,595		1,905,595	7,811	1,913,406			10
10a	Therapy	49,783	442	6,018	56,243		56,243	2,142	58,385			10a
11	Activities	95,497	11,822	3,736	111,055		111,055	479	111,534			11
12	Social Services	55,849		1,406	57,255		57,255	1,293	58,548			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,339	3,339			15
16	**TOTAL Health Care and Programs**	1,949,602	86,453	110,878	2,146,933		2,146,933	15,063	2,161,996			16
	C. General Administration											
17	Administrative	36,533		34,644	71,177		71,177	31,478	102,655			17
18	Directors Fees											18
19	Professional Services			154,582	154,582		154,582	(117,552)	37,030			19
20	Dues, Fees, Subscriptions & Promotions			47,252	47,252		47,252	(20,344)	26,908			20
21	Clerical & General Office Expenses	104,352	22,033	89,188	215,573		215,573	25,348	240,921			21
22	Employee Benefits & Payroll Taxes			441,384	441,384	21,280	462,664	(7,465)	455,198			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,785	1,785		1,785	(874)	911			24
25	Other Admin. Staff Transportation			2,063	2,063		2,063	(1,486)	577			25
26	Insurance-Prop.Liab.Malpractice			165,382	165,382		165,382	1,235	166,617			26
27	Other (specify):*							17,567	17,567			27
28	**TOTAL General Administration**	140,885	22,033	936,280	1,099,198	21,280	1,120,478	(72,094)	1,048,384			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,653,608	338,835	1,297,049	4,289,492		4,289,492	(53,119)	4,236,373			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRVIEW NURSING HOME #0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,376	63,376		63,376	130,207	193,583			30
31	Amortization of Pre-Op. & Org.			1,644	1,644		1,644	9,326	10,970			31
32	Interest			118,851	118,851		118,851	478,380	597,231			32
33	Real Estate Taxes			210,585	210,585		210,585	6,406	216,991			33
34	Rent-Facility & Grounds			633,548	633,548		633,548	(627,936)	5,612			34
35	Rent-Equipment & Vehicles			7,374	7,374		7,374	2,811	10,185			35
36	Other (specify):*											36
37	TOTAL Ownership			1,035,378	1,035,378		1,035,378	(806)	1,034,572			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,862	213,004	365,866		365,866	(15,401)	350,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		152,862	284,727	437,589		437,589	(15,401)	422,188			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,653,608	491,697	2,617,154	5,762,459		5,762,459	(69,326)	5,693,133			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,373)	30		9
10	Interest and Other Investment Income	(40,319)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(369)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,985)	20		28
29	Other-Attach Schedule	(68,539)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (145,585)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	76,259		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,259		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (69,326)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FAIRVIEW NURSING HOME

ID# 0038745

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising & Promotions	$ (11,246)	20	1
2	Veterans Expense	(10,810)	10	2
3	LLC Fee (Building Partnership)	(200)	19	3
4	Collection Expense	(1,719)	21	4
5	Theft Loss	(487)	21	5
6	Jury Duty-Misc Income	(17)	10	6
7	Incontinence Income	(788)	10	7
8	Furniture & Fixtures (Prior Period Adj)	(1,580)	06	8
9	ICLTC COPE Payment	(2,401)	20	9
10	Late Charges	(904)	32	10
11	Legal Expense (Prior Period)	(603)	19	11
12	Def Replacement Tax (Prior Period)	(20,300)	21	12
13	Ancillary Services (Prior Period)	(12,800)	39	13
14	Bank Charges (Building Partnership)	(5)	21	14
15	Bank Charges (Facility)	(2,043)	21	15
16	Utility Expense (Building Partnership)	(853)	05	16
17	Seminar Expense (Unaccounted Invoices)	(1,785)	24	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,323	(2,391)		(9,030)						(8,098)	1
2	Food Purchase	(369)		(312)			6,955						6,274	2
3	Housekeeping			1,300									1,300	3
4	Laundry													4
5	Heat and Other Utilities	(853)	853	1,722									1,722	5
6	Maintenance	(1,580)		9,539	(6,949)		1						1,011	6
7	Other (specify):*			1,346			357						1,703	7
8	**TOTAL General Services**	(2,802)	853	16,918	(9,340)		(1,717)						3,911	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,613)		19,466	(3,779)		65	(2,357)		6,029			7,811	10
10a	Therapy			3,881	(1,739)								2,142	10a
11	Activities			1,503	(1,024)								479	11
12	Social Services			1,413	(120)								1,293	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,339									3,339	15
16	**TOTAL Health Care and Programs**	(11,613)		29,602	(6,663)		65	(2,357)		6,029			15,063	16
	C. General Administration													
17	Administrative			31,308	(31,469)	31,469	170						31,478	17
18	Directors Fees													18
19	Professional Services	(803)	200	4,589	(105,327)		33			(16,244)			(117,552)	19
20	Fees, Subscriptions & Promotions	(15,632)		1,250	(5,977)		15						(20,344)	20
21	Clerical & General Office Expenses	(54,554)	5	89,788	(12,228)		299			2,038			25,348	21
22	Employee Benefits & Payroll Taxes				(8,596)					1,131			(7,465)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,785)		909			2						(874)	24
25	Other Admin. Staff Transportation			49	(1,878)		343						(1,486)	25
26	Insurance-Prop.Liab.Malpractice			882						353			1,235	26
27	Other (specify):*			13,610		3,957							17,567	27
28	**TOTAL General Administration**	(72,774)	205	142,385	(165,476)	35,426	862			(12,722)			(72,094)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,189)	1,058	188,905	(181,479)	35,426	(790)	(2,357)		(6,693)			(53,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(4,373)	127,839	6,741									130,207	30
31	Amortization of Pre-Op. & Org.		9,326										9,326	31
32	Interest	(41,223)	511,985	7,055			5			558			478,380	32
33	Real Estate Taxes		3,908	2,498									6,406	33
34	Rent-Facility & Grounds		(633,548)	3,429						2,183			(627,936)	34
35	Rent-Equipment & Vehicles			2,582			18			211			2,811	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(45,596)	19,510	22,305			23			2,952			(806)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(12,800)					(2,601)						(15,401)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(12,800)					(2,601)						(15,401)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(145,585)	20,568	211,210	(181,479)	35,426	(3,368)	(2,357)		(3,741)			(69,326)	45

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Fairview Healthcare Properties		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 633,548	Fairview Health Care Properties	100.00%	$	$ (633,548)	1
2	V	32	Interest Income		Fairview Health Care Properties	100.00%	(17,450)	(17,450)	2
3	V	32	Interest Expense		Fairview Health Care Properties	100.00%	529,435	529,435	3
4	V	21	Bank Charges		Fairview Health Care Properties	100.00%	5	5	4
5	V	33	Real Estate Tax		Fairview Health Care Properties	100.00%	3,908	3,908	5
6	V	30	Depreciation		Fairview Health Care Properties	100.00%	127,839	127,839	6
7	V	31	Amortization		Fairview Health Care Properties	100.00%	9,326	9,326	7
8	V	19	LLC Fee		Fairview Health Care Properties	100.00%	200	200	8
9	V	05	Utility Expense		Fairview Health Care Properties	100.00%	853	853	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 633,548			$ 654,116	$ * 20,568	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,323	$ 3,323	15
16	V	2	FOOD				(312)	(312)	16
17	V	3	HOUSEKEEPING				1,300	1,300	17
18	V	5	UTILITIES				1,722	1,722	18
19	V	6	REPAIRS AND MAINT.				9,539	9,539	19
20	V	7	EMP. BEN. - GEN. SERV.				1,346	1,346	20
21	V	10	NURSING				19,466	19,466	21
22	V	10A	THERAPY				3,881	3,881	22
23	V	11	ACTIVITIES				1,503	1,503	23
24	V	12	SOCIAL SERVICES				1,413	1,413	24
25	V	15	EMP. BEN. - HEALTHCARE				3,339	3,339	25
26	V	17	ADMINISTRATIVE				31,308	31,308	26
27	V	19	PROFESSIONAL FEES				4,589	4,589	27
28	V	20	DUES, SUBSCRIPTIONS				1,250	1,250	28
29	V	21	CLERICAL AND GENERAL				89,788	89,788	29
30	V	24	SEMINARS				909	909	30
31	V	25	AUTO EXPENSE				49	49	31
32	V	26	INSURANCE				882	882	32
33	V	27	EMP. BEN. - GEN. ADMIN.				13,610	13,610	33
34	V	30	DEPRECIATION				6,741	6,741	34
35	V	32	INTEREST				7,055	7,055	35
36	V	33	REAL ESTATE TAXES				2,498	2,498	36
37	V	34	BUILDING RENT - UNRELATED				3,429	3,429	37
38	V	35	EQUIPMENT RENTAL				2,582	2,582	38
39	Total			$			$ 211,210	$ * 211,210	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 2,391	CARE CENTERS, INC.	100.00%	$	$ (2,391)	15
16	V	19	ACCOUNTING	13,500				(13,500)	16
17	V	19	ANCIL ADMIN FEE	7,860				(7,860)	17
18	V	19	BOOKEEPING	13,362				(13,362)	18
19	V	19	DATA PROCESSING	2,358				(2,358)	19
20	V	19	LEGAL	5,977				(5,977)	20
21	V	19	MANAGEMENT FEE	55,020				(55,020)	21
22	V	19	PROFESSIONAL FEES	7,250				(7,250)	22
23	V	20	ADVERTISING	5,977				(5,977)	23
24	V	25	REBILL BUS	1,878				(1,878)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	8,596				(8,596)	26
27	V	1	REBILL. PAYROLL DIETARY						27
28	V	3	REBILL. PAYROLL HSKPNG						28
29	V	6	REBILL. PAYROLL MAINT.	6,949				(6,949)	29
30	V	10	REBILL. PAYROLL NURSING	3,779				(3,779)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	1,739				(1,739)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	1,024				(1,024)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	120				(120)	33
34	V	17	REBILL. PAYROLL ADMIN.	31,469				(31,469)	34
35	V	21	REBILL. PAYROLL CLERICAL	12,228				(12,228)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 181,479			$	$ * (181,479)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$	$	15
16	V	15	EMP. BEN HEALTHCARE						16
17	V	17	ADMINISTRATIVE				31,469	31,469	17
18	V	27	EMP. BEN GEN. ADMIN.				3,957	3,957	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 35,426	$ * 35,426	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 3,929	$ 3,929	15
16	V	2	FOOD				6,955	6,955	16
17	V	6	MAINTENANCE				1	1	17
18	V	7	EMP. BEN. - GEN. SERV.				357	357	18
19	V	10	NURSING				65	65	19
20	V	17	ADMINISTRATIVE				170	170	20
21	V	19	PROFESSIONAL FEES				33	33	21
22	V	20	DUES, FEES, SUB.				15	15	22
23	V	21	CLERICAL & GENERAL				299	299	23
24	V	24	SEMINARS				2	2	24
25	V	25	TRAVEL				343	343	25
26	V	32	INTEREST				5	5	26
27	V	35	RENT - EQUIPMENT & VEHICLES				18	18	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				227	227	28
29	V	1	DIETARY SUPP	12,959				(12,959)	29
30	V	39	ANCILLARY SUPP	2,828				(2,828)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,787			$ 12,419	$ * (3,368)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 19,410	$ 19,410	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	21,767				(21,767)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,767			$ 19,410	$ * (2,357)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 90,875	$ 90,875	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	90,875				(90,875)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,875			$ 90,875	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Consultant	$	Pinnacle Care Health Services LLC		$ 6,029	$ 6,029	15
16	V	21	Office		Pinnacle Care Health Services LLC		2,038	2,038	16
17	V	22	Employee Benefits		Pinnacle Care Health Services LLC		1,131	1,131	17
18	V	26	Insurance		Pinnacle Care Health Services LLC		353	353	18
19	V	32	Interest		Pinnacle Care Health Services LLC		558	558	19
20	V	34	Building Rental		Pinnacle Care Health Services LLC		2,183	2,183	20
21	V	35	Equipment Rental		Pinnacle Care Health Services LLC		211	211	21
22	V	19	Home Office Expense	16,244	Pinnacle Care Health Services LLC			(16,244)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,244			$ 12,503	$ * (3,741)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	4.29%	See Attached	1.35	2.00%		$		1
2	Ariel Goldberg	Clerical	Administrative	0.00%	See Attached	.12	3.00%	Salary Alloc	69	21-7	2
3	Zev Goldberg	Clerical	Administrative	0.00%	See Attached	.71	3.00%	Salary Alloc	459	21-7	3
4	Norm Goldberg	Owner	Administrative	0.34%	See Attached	1.37	2.74%	Salary Alloc	2,770	17-7	4
5	Nathan Langsner	Owner	Administrative	1.03%	See Attached	1.10	2.75%	Salary Alloc	2,024	17-7	5
6	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.37	2.74%	Salary Alloc	1,219	17-7	6
7	Ron Abrams	Owner	Administrative	3.43%	See Attached	.25	0.71%				7
8	Alan Abrams	Owner	Administrative	3.43%	See Attached	.25	0.71%				8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,541		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	41,790	$ 3,323	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		41,790	(312)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	41,790	1,300	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		41,790	1,722	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	41,790	9,539	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		41,790	1,346	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	41,790	19,466	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	41,790	3,881	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	41,790	1,503	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	41,790	1,413	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		41,790	3,339	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	41,790	31,308	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		41,790	4,589	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		41,790	1,250	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	41,790	89,788	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		41,790	909	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		41,790	49	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		41,790	882	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		41,790	13,610	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		41,790	6,741	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		41,790	7,055	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		41,790	2,498	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		41,790	3,429	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		41,790	2,582	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 211,210	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		31,469	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			3,957	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 35,426	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	15,787	3,929	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		15,787	6,955	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		15,787	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		15,787	357	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		15,787	65	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		15,787	170	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		15,787	33	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		15,787	15	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		15,787	299	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		15,787	2	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		15,787	343	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		15,787	5	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		15,787	18	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		15,787	227	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 12,419	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 19,410	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 19,410	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 90,875	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 90,875	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Pinnacle Care Health Services LLC
Street Address: 1010 Milwaukee Ave.
City / State / Zip Code: Deerfield, IL 60015
Phone Number: ((847) 541-9100
Fax Number: ((847) 541-9015

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nurse Consultant	Patient Days	158,482	3	$ 22,864	$	41,790	$ 6,029	1
2	21	Office Expenses	Patient Days	158,482	3	7,729		41,790	2,038	2
3	22	Employee Benefits	Patient Days	158,482	3	4,287		41,790	1,131	3
4	26	Insurance	Patient Days	158,482	3	1,340		41,790	353	4
5	32	Interest	Patient Days	158,482	3	2,115		41,790	558	5
6	34	Building Rental	Patient Days	158,482	3	8,280		41,790	2,183	6
7	35	Equipment Rental	Patient Days	158,482	3	800		41,790	211	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 47,415	$		$ 12,503	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/P Nomura		X	Mortgage			$ 5,906,356	$ 5,457,181			$ 529,435	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Working Capital				1,603,569			108,883	6
7	Ins Premium		X	Insurance Financing							7,146	7
8	Hunter Management	X		Working Capital				100,000			1,917	8
9	TOTAL Facility Related						$ 5,906,356	$ 7,160,750			$ 647,382	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(50,709)	10
11	Alloc from Pinnacle Care										558	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (50,151)	14
15	TOTALS (line 9+line14)						$ 5,906,356	$ 7,160,750			$ 597,231	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (40,319)	1
2	Interest Income (Bldg. Co.)										(17,450)	2
3	Allocated from Care Center										7,060	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (50,709)	21

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	188,399	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	203,742	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,343	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	201,648	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 5,936 For 19 96 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	216,991	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	200,280	8
	1997	198,255	9
	1998	200,541	10
	1999	188,374	11
	2000	197,336	12

2001 Accrual - 197,336*104.5%=206,216-$4505(Int.Inc.on Escrow Acct.)=$201,711

Fairview HC Prop. $3908

Care Center Alloc. $2,498

Refund of $5,936 relates to 1996 Tax Year which was not used to calculate a rate.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0038745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-33-128-011-0000	Facility	$ 118,269.22	$ 118,269.22
2.	15-33-128-010-0000	Facility	$ 79,066.67	$ 79,066.67
3.			$	$
4.			$	$
5.	See Attached	Allocated Home Office R/E Tax	$ 66,986.83	$ 1,838.82
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 264,322.72	$ 199,174.71

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 10,970 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility (Fairview HC Properties)		1994	$ 321,372	1
2	Allocation from Care Center			1,757	2
3	TOTALS			$ 323,129	3

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	8,764			438	438	3,713	9
10	Various			1994	40,683			1,889	1,889	13,935	10
11	Various			1995	126,067			6,306	6,306	39,491	11
12	Various			1996	72,442			3,623	(3,623)	20,825	12
13	Various			1997	21,779			1,090	1,090	4,844	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		4,364,257	111,935		112,215	280	844,046	68
69	Financial Statement Depreciation			22,402			(22,402)		69
70	TOTAL (lines 4 thru 69)		$ 4,633,992	$ 134,337		$ 125,561	$ (16,022)	$ 926,854	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,633,992	$ 134,337		$ 125,561	$ (8,776)	$ 926,854	1
2	PLUMBING RENOV.	1998	2,971			149	149	596	2
3	HVAC RENOV.	1998	5,666			283	283	1,132	3
4	ELEVATOR RENOV.	1998	4,048			202	202	808	4
5	PLUMBING RENOV.	1998	1,024			51	51	200	5
6	PLUMBING REONV.	1998	4,689			234	234	897	6
7	WALLPAPER	1998	2,800			140	140	537	7
8	HVAC RENOV.	1998	7,095			355	355	1,361	8
9	ELECTRICAL	1998	798			40	40	153	9
10	CUBICLE CURTAINS	1998	4,651			233	233	874	10
11	WALLPAPER	1998	3,134			157	157	576	11
12	ACROUYN BUMPERS	1998	1,884			94	94	345	12
13	CUBICLE CURTAINER	1998	4,227			211	211	774	13
14	COVE BASE	1998	577			29	29	106	14
15	FLOOR RENOV.	1998	12,208			610	610	2,237	15
16	PLUMBING RENOV.	1998	2,065			103	103	369	16
17	DRYWALL	1998	2,700			135	135	484	17
18	HVAC RENOV.	1998	4,565			228	228	817	18
19	PLUMBING RENOV	1998	5,793			290	290	1,136	19
20	WALLPAPER	1998	4,745			237	237	928	20
21	ROOF RENOV	1998	21,028			1,051	1,051	4,029	21
22	HVAC RENOV	1998	2,530			127	127	487	22
23	CUBICLE CURTAINS	1998	18,143			907	907	3,401	23
24	PLUMBING RENOV	1998	1,644			82	82	287	24
25	ELECTRICAL	1998	995			50	50	175	25
26	HVAC RENOV	1998	5,410			271	271	949	26
27	PLUMBING RENOV	1998	7,358			368	368	1,257	27
28	HVAC RENOV	1998	19,149			957	957	3,270	28
29	PAINTING/DECOR	1998	3,140			157	157	536	29
30	PLUMBING	1998	1,771			89	89	297	30
31	HVAC RENOV	1998	4,561			228	228	760	31
32	FREEZER RENOV	1998	1,011			51	51	170	32
33	HVAC RENOV	1998	1,255			63	63	205	33
34	TOTAL (lines 1 thru 33)		$ 4,797,627	$ 134,337		$ 133,743	$ (594)	$ 957,007	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,797,627	$ 134,337		$ 133,743	$ (594)	$ 957,007	1
2	PLUMBING	1998	944			47	47	153	2
3	WALL A/C	1998	3,041			152	152	494	3
4	ELECTRICAL	1998	750			38	38	124	4
5	PLUMBING	1998	657			33	33	105	5
6	DOOR	1998	886			44	44	139	6
7	WALL A/C	1998	3,041			152	152	481	7
8	HVAC RENOV	1998	2,298			115	115	364	8
9	HVAC	1998	1,895			95	95	356	9
10	PLUMBING RENOVATION	1998	512			26	26	78	10
11	SMOKE DAMPERS	1998	4,850			243	243	729	11
12	WALLPAPER	1998	2,135			107	107	321	12
13	PAD DOORS	1998	4,398			220	220	660	13
14	PLUMBING RENOVATION	1998	972			49	49	135	14
15	HVAC RENOVATION	1998	2,512			126	126	347	15
16	HVAC RENOVATION	1998	2,843			142	142	391	16
17	HVAC RENOVATION	1998	5,617			281	281	773	17
18	SMOKE DAMPERS	1999	5,840			292	292	876	18
19	DRYWALL	1999	755			38	38	114	19
20	AC RENOVATION	1999	934			47	47	141	20
21	PLUMBING RENOVATION	1999	577			29	29	87	21
22	FIRE ALARM SYSTEM	1999	1,160			58	58	174	22
23	HVAC RENOVATION	1999	2,149			107	107	312	23
24	PLUMBING RENOVATION	1999	911			46	46	134	24
25	ELEVATOR RENOVATION	1999	1,268			63	63	184	25
26	ELECTRICAL RENOV.	1999	1,015			51	51	149	26
27	PLUMBING RENOVATION	1999	880			44	44	125	27
28	ELECTRICAL RENOV.	1999	989			49	49	139	28
29	FIRE ALARM SYSTEM	1999	1,055			53	53	150	29
30	HVAC RENOVATION	1999	900			45	45	124	30
31	PLUMBING RENOVATION	1999	1,725			86	86	222	31
32	WIRING	1999	750			38	38	98	32
33	PAINT	1999	3,682			184	184	460	33
34	TOTAL (lines 1 thru 33)		$ 4,859,568	$ 134,337		$ 136,843	$ 2,506	$ 966,146	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,859,568	$ 134,337		$ 136,843	$ 2,506	$ 966,146	1
2	HVAC RENOVATION	1999	995			50	50	121	2
3	FIRE DAMPER	1999	2,750			138	138	334	3
4	AIR UNITS	1999	1,520			76	76	184	4
5	AIR UNITS	1999	1,520			76	76	184	5
6	HVAC	1999	640			32	32	77	6
7	HVAC RENOVATION	1999	1,520			76	76	177	7
8	HVAC RENOVATION	1999	1,685			84	84	196	8
9	HVAC RENOVATION	1999	1,520			76	76	177	9
10	HVAC RENOVATION	1999	518			26	26	61	10
11	FIRE DAMPER	1999	2,750			138	138	311	11
12	HVAC	1999	1,520			76	76	171	12
13	HVAC	1999	1,685			84	84	189	13
14	REPLACE FAUCETS	1999	597			30	30	68	14
15	HOT WATER LINE	1999	898			45	45	101	15
16	PIPE TRAPS	1999	822			41	41	92	16
17	HVAC RENOVATION	1999	1,685			84	84	182	17
18	A/C RENOV	1999	1,685			84	84	175	18
19	PLUMBING RENOV	1999	850			43	43	90	19
20	SECURITY SYSTEM	1999	977			49	49	118	20
21	FAUCET	1999	724			36	36	84	21
22	TELEPHONE SYSTEM	1999	13,242			662	662	1,379	22
23	LABELS FOR BOILER	2000	1,137			57	57	71	23
24	DOORS	2000	955			48	48	60	24
25	ELECTRIC WIRING	2000	600			30	30	35	25
26	PLUMBING RENOV	2000	903			45	45	86	26
27	CONDENSOR RENOV	2000	875			44	44	84	27
28	ZONE VALVE	2000	507			51	51	98	28
29	INDUSTRIAL MOTOR	2000	528			53	53	97	29
30	BOILER INSULATION	2000	1,131			113	113	207	30
31	BOILER RENOV	2000	516			52	52	91	31
32	PANIC DEVICE	2000	576			58	58	102	32
33	PAINT	2000	888			44	44	70	33
34	TOTAL (lines 1 thru 33)		$ 4,908,287	$ 134,337		$ 139,444	$ 5,107	$ 971,618	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,908,287	$ 134,337		$ 139,444	$ 5,107	$ 971,618	1
2	PLUMBING REPAIR	2000	3,071			154	154	244	2
3	WIRING	2000	585			29	29	44	3
4	DOORS	2000	1,980			99	99	149	4
5	DOORS	2000	1,600			80	80	120	5
6	DOORS	2000	1,425			71	71	107	6
7	FIRE ALARM, SPRINKLE	2000	184,600			9,230	9,230	13,845	7
8	PLUMBING	2000	1,443			72	72	108	8
9	AC WORK	2000	3,478			174	174	261	9
10	AC WORK	2000	3,478			174	174	261	10
11	AC WORK	2000	1,827			91	91	137	11
12	MASONRY RESTORATION	2000	1,435			72	72	102	12
13	LOUNGE ROOM IN BSMNT	2000	2,300			115	115	125	13
14	PAINT	2000	2,236			112	112	121	14
15	ARCHITECT FEES	2000	729			36	36	39	15
16	TOILET REPAIR	2000	522			26	26	28	16
17	A/C REPAIR	2000	551			28	28	30	17
18	A/C REPAIR	2000	814			41	41	44	18
19	A/C REPAIR	2000	505			25	25	27	19
20	WALL A/C UNITS	2000	1,685			84	84	161	20
21	REPLACE A/C	2000	3,478			174	174	276	21
22	AC REPAIR	2000	574			29	29	46	22
23	AC WORK	2000	598			30	30	43	23
24	AC WORK	2000	2,640			132	132	187	24
25	AC WORK	2000	687			34	34	48	25
26	AC WORK	2000	3,478			174	174	247	26
27	AC WORK	2000	4,521			226	226	320	27
28	AC WORK	2000	1,479			74	74	99	28
29	THERMOSTAT REPAIR	2001	585			29	29	29	29
30	SEWER REPAIR	2001	688			34	34	34	30
31	REPAIR NURSE CALL SY	2001	572			29	29	29	31
32	BOILER REPAIR	2001	861			39	39	39	32
33	BOILER REPAIR	2001	678			31	31	31	33
34	TOTAL (lines 1 thru 33)		$ 5,143,390	$ 134,337		$ 151,192	$ 16,855	$ 988,999	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,143,390	$ 134,337		$ 151,192	$ 16,855	$ 988,999	1
2	SEWER REPAIR	2001	1,355			57	57	57	2
3	ELEVATOR REPAIR	2001	470			20	20	20	3
4	FIRE ALARM REPAIR	2001	1,494			56	56	56	4
5	WIRING	2001	725			27	27	27	5
6	DOOR REPAIR	2001	650			25	25	25	6
7	PAINT	2001	708			23	23	23	7
8	SIGN	2001	3,354			112	112	112	8
9	CARPET	2001	565			16	16	16	9
10	PAINT	2001	410			12	12	12	10
11	PAINT	2001	586			17	17	17	11
12	PAINT	2001	656			19	19	19	12
13	LANDSCAPING	2001	1,093			32	32	32	13
14	WEATHER STRIPPER	2001	1,580			40	40	40	14
15	FIRE SPRINKLER SYSTE	2001	5,900			148	148	148	15
16	PAINTING	2001	18,626			466	466	466	16
17	LIGHTING	2001	16,856			351	351	351	17
18	LIGHT COVERS	2001	510			9	9	9	18
19	ELECTRICAL WIRING	2001	725			12	12	12	19
20	FIRE ALARM CNTRL PAN	2001	1,259			21	21	21	20
21	SATELLITE SYSTEM	2001	9,330			117	117	117	21
22	PLUMBING REPAIR	2001	521			7	7	7	22
23	HAND RAIL EXTENDED	2001	2,324			19	19	19	23
24	GAS VALVE	2001	913			8	8	8	24
25	TEMPERING VALVES	2001	787			7	7	7	25
26	HEAT EXCHANGER	2001	1,050			9	9	9	26
27	DUCT FURNACE	2001	1,112			5	5	5	27
28	MOD MOTOR	2001	843			4	4	4	28
29	PLUMBING REPAIR	2001	546			2	2	2	29
30	CUBICLE CURTAINS	2001	12,500			52	52	52	30
31	ELECTRICAL WIRING	2001	3,525			15	15	15	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,234,363	$ 134,337		$ 152,900	$ 18,563	$ 990,707	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc		1996		$ 31,091	$ 797	35	$ 888	$ 91	$ 4,516	4
5	CCI										5
6			1994		4,323,142	110,850	35	110,850		835,993	6
7											7
8											8
	Improvement Type**										
9	Fairview Health Care Properties			1995	1,888	48	20	48		1,562	9
10											10
11	Care Center Allocation			2001	89	12	20	2	(10)	2	11
12	Care Center Allocation			2000	37	1	20	2	(1)	3	12
13	Care Center Allocation			1999	557	14	20	28	14	81	13
14	Care Center Allocation			1998	230	6	20	12	6	42	14
15	Care Center Allocation			1997	3,261	58	20	180	122	1,051	15
16	Care Center Allocation			1996	3,584	47	20	189	142	743	16
17	Care Center Allocation			1994	-	11	20	-	(11)	-	17
18	Care Center Allocation			1993	-	3	20	-	(3)	-	18
19											19
20	Care Center Allocation			1997	378	88	20	16	(72)	53	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,364,257	$ 111,935		$ 112,215	$ 278	$ 844,046	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 593,003	$ 63,352	$ 38,864	$ (24,488)		$ 457,269	71
72	Current Year Purchases	30,869	267	1,819	1,552		1,819	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 623,872	$ 63,619	$ 40,683	$ (22,936)		$ 459,088	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,181,364	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 197,956	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,583	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,373)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,449,795	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Center Allocation				3,429			5
6	Pinnacle Care Allocation				2,183			6
7	TOTAL				$ 5,612 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,185 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 44,369	$		$ 44,369	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,850			6,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			161,785	12,800		174,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				103,631		103,631	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						36,431		36,431	13
14	TOTAL			$		$ 213,004	$ 152,862		$ 365,866	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (65,975)	$ (40,686)	1
2	Cash-Patient Deposits	44,255	44,255	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,007,020	1,007,853	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,046	54,046	6
7	Other Prepaid Expenses	77,540	77,540	7
8	Accounts Receivable (owners or related parties)	819,303	749,768	8
9	Other(specify): See supplemental schedule	9,330	146,418	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,945,519	$ 2,039,194	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		321,372	13
14	Buildings, at Historical Cost		4,325,031	14
15	Leasehold Improvements, at Historical Cost	734,704	734,704	15
16	Equipment, at Historical Cost	277,097	653,458	16
17	Accumulated Depreciation (book methods)	(273,384)	(1,486,064)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		114,911	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(58,129)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	274	274	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 738,691	$ 4,605,557	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,684,210	$ 6,644,751	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 345,851	$ 345,852	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,763	43,763	28
29	Short-Term Notes Payable	1,703,569	1,703,569	29
30	Accrued Salaries Payable	195,241	195,241	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,379	31,379	31
32	Accrued Real Estate Taxes(Sch.IX-B)	201,648	201,648	32
33	Accrued Interest Payable		26,922	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	334,704	334,704	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,856,155	$ 2,883,078	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,457,181	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,457,181	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,856,155	$ 8,340,259	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (171,945)	$ (1,695,508)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,684,210	$ 6,644,751	48

*(See instructions.)

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,739	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,739	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,684)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (175,684)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (171,945)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,401,649	1
2	Discounts and Allowances for all Levels	(1,215,543)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,186,106	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,121,549	6
7	Oxygen	31,664	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,153,213	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,005	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,698	19
20	Radiology and X-Ray	1,380	20
21	Other Medical Services	77,093	21
22	Laundry	1,444	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 200,620	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40,319	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,319	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	6,517	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,517	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,586,775	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,043,361	31
32	Health Care	2,146,933	32
33	General Administration	1,099,198	33
	B. Capital Expense		
34	Ownership	1,035,378	34
	C. Ancillary Expense		
35	Special Cost Centers	365,866	35
36	Provider Participation Fee	71,723	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,762,459	40
41	**Income before Income Taxes (line 30 minus line 40)****	(175,684)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (175,684)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,887	2,119	$ 62,887	$ 29.68	1
2	Assistant Director of Nursing	1,702	2,121	58,355	27.51	2
3	Registered Nurses	12,797	14,600	310,808	21.29	3
4	Licensed Practical Nurses	21,138	24,256	492,233	20.29	4
5	Nurse Aides & Orderlies	70,383	79,191	790,187	9.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,821	4,337	49,783	11.48	8
9	Activity Director	1,280	1,410	20,918	14.84	9
10	Activity Assistants	8,912	9,418	74,579	7.92	10
11	Social Service Workers	3,820	4,254	55,849	13.13	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,225	28,400	12.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,591	19,172	156,245	8.15	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,221	37,514	16.89	17
18	Housekeepers	25,639	27,888	251,004	9.00	18
19	Laundry	8,582	9,590	89,958	9.38	19
20	Administrator	1,419	1,519	36,533	24.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,036	5,746	104,352	18.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,752	2,169	34,003	15.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,775	212,236	$ 2,653,608 *	$ 12.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	261/Monthly	$ 15,526	01-03	35
36	Medical Director	Monthly	16,785	09-03	36
37	Medical Records Consultant	Monthly	1,882	10-03	37
38	Nurse Consultant	Monthly	1,530	10-03	38
39	Pharmacist Consultant	Monthly	2,396	10-03	39
40	Physical Therapy Consultant	91	1,825	10a-03	40
41	Occupational Therapy Consultant	49	2,454	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	2,712	11-03	44
45	Social Service Consultant	Monthly	1,286	12-03	45
46	Other(specify)				46
47					47
48	CCI Salary-(See Attached)		6,662		48
49	TOTAL (lines 35 - 48)	197	$ 53,058		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	926	16,455	10-03	51
52	Nurse Aides	3,371	56,891	10-03	52
53	TOTAL (lines 50 - 52)	4,297	$ 73,346		53

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Salary pd CCI-01/01/01-06/30/01	Administrator		$
David Hajduch-07/01/01-07/31/01	Administrator	0%	3,200
Sue Bohne-(08/01/01-12/31/01)	Administrator	0%	33,333
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,533

B. Administrative - Other

Description	Amount
Chris Wayer - Management Fee	$ 3,175
Administrative Payroll adjusted on page 6	31,469
TOTAL (agree to Schedule V, line 17, col. 3)	$ 34,644
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 23,490
IIT/Sourcetech	Computer	775
Crowe Chizek	Accounting	502
Personnel Planners	Unemployment Consulting	500
Maxxsource	Computer	200
Alpha Data Services	Computer	4,146
American Tax Service	Accounting	637
Winston & Strawn	Legal-(PPA-Adj on Pg 5a)	603
Meyer Magence	Legal	2,158
Pinnacle Care	Home Office Expense	16,244
Care Centers, Inc.	See Attached	105,327
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 154,582

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,399
Unemployment Compensation Insurance	25,671
FICA Taxes	203,001
Employee Health Insurance	105,819
Employee Meals	21,280
Illinois Municipal Retirement Fund (IMRF)*	
Pension	20,121
Employee Physicals	2,212
Miscellaneous Employee Welfare	16,845
Christmas Expense	720
Pinnacle Care allocation	1,131
TOTAL (agree to Schedule V, line 22, col.8)	$ 455,198

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	13,523
Health Care Worker Background Check	
(Indicate # of checks performed 75)	910
Yellow Page Advertising	1,985
Advertising & Promotion	17,223
Due & Subscriptions	5,431
Licenses & Fees	7,780
CCI Allocation	1,265
Illinois Council LTC (COPE)	(2,401)
Less: Public Relations Expense	
Non-allowable advertising	(17,223)
Yellow page advertising	(1,985)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,908

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
CCI Allocation	912
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 912

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRVIEW NURSING HOME # 0038745 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on LTC-$3,137.07**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,672** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **71,723**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,280** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Frost, Ruttenberg & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not Complete as of 03-31-02**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees